

		FOR OHF USE					

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**2005**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2005)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0030411</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>CARLINVILLE REHAB &amp; HCC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2004</u> to <u>6/30/2005</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>751 N. OAK STREET</u> <u>CARLINVILLE</u> <u>62626</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>MACOUPIN</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____	
<b>Telephone Number:</b> <u>217-854-2511</u> <b>Fax #</b> <u>217-854-4377</u>		(Type or Print Name) <u>Junior Foster, THSCLLC, Mgt. Co for</u>	
<b>IDPA ID Number:</b> <u>51-0271905</u>		(Title) <u>SUNSHINE MANOR</u>	
<b>Date of Initial License for Current Owners:</b> <u>10/1/85</u>		(Signed) _____ (Date) _____	
<b>Type of Ownership:</b>		<b>Paid Preparer</b> (Print Name and Title) _____	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT		(Firm Name & Address) _____	
<input checked="" type="checkbox"/> Charitable Corp.		(Telephone) <u>( )</u> <b>Fax #</b> ( )	
<input type="checkbox"/> Trust		<b>MAIL TO: BUREAU OF HEALTH FINANCE</b>	
<b>IRS Exemption Code</b> _____		<b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>	
<input type="checkbox"/> PROPRIETARY		<b>201 S. Grand Avenue East</b>	
<input type="checkbox"/> Individual		<b>Springfield, IL 62763-0001</b>	
<input type="checkbox"/> Partnership		<b>Phone # (217) 782-1630</b>	
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
<b>GOVERNMENTAL</b>			
<input type="checkbox"/> State			
<input type="checkbox"/> County			
<input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b>			
<b>Name:</b> <u>Ken Marx, BKD, LLP</u>			
<b>Telephone Number:</b> <u>314-231-5544</u>			

## STATE OF ILLINOIS

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Facility Name & ID Number CARLINVILLE REHAB & HCC# 0030411 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)	98	35,770	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7		TOTALS	98	35,770	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	15,780	7,244	2,645	25,669	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,780	7,244	2,645	25,669	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 71.76%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)N/A NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 10/1/85

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 10/1/85 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified 98 and days of care provided 2,645Medicare Intermediary MUTUAL OF OMAHA

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED  
CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 6/30/05 Fiscal Year: 6/30/05

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number

CARLINVILLE REHAB &amp; HCC

# 0030411

Report Period Beginning:

7/1/2004

Ending:

6/30/2005

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	105,128	5,903	8,926	119,957		119,957	(5,144)	114,813		1
2	Food Purchase		115,878		115,878		115,878	(442)	115,436		2
3	Housekeeping		8,749	82,263	91,012		91,012		91,012		3
4	Laundry		8,750	53,930	62,680		62,680		62,680		4
5	Heat and Other Utilities			71,673	71,673		71,673		71,673		5
6	Maintenance	31,105	7,683	29,989	68,777		68,777		68,777		6
7	Other (specify):*			1,879	1,879		1,879		1,879		7
8	<b>TOTAL General Services</b>	136,233	146,963	248,660	531,856		531,856	(5,586)	526,270		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			11,518	11,518		11,518		11,518		9
10	Nursing and Medical Records	889,824	52,987	5,431	948,242		948,242		948,242		10
10a	Therapy		764	110,431	111,195		111,195		111,195		10a
11	Activities	36,822	2,947	4,392	44,161		44,161		44,161		11
12	Social Services	62,034	108	2,528	64,670		64,670		64,670		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	988,680	56,806	134,300	1,179,786		1,179,786		1,179,786		16
	<b>C. General Administration</b>										
17	Administrative	69,798			69,798		69,798		69,798		17
18	Directors Fees										18
19	Professional Services			253,469	253,469		253,469	2,066	255,535		19
20	Dues, Fees, Subscriptions & Promotions			41,247	41,247		41,247	(26,529)	14,718		20
21	Clerical & General Office Expenses	48,187	14,942	41,810	104,939		104,939	(26,689)	78,250		21
22	Employee Benefits & Payroll Taxes			204,634	204,634		204,634	6,230	210,864		22
23	Inservice Training & Education			2,974	2,974		2,974		2,974		23
24	Travel and Seminar			16,268	16,268		16,268	673	16,941		24
25	Other Admin. Staff Transportation			7,918	7,918		7,918		7,918		25
26	Insurance-Prop.Liab.Malpractice			100,233	100,233		100,233	3,663	103,896		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	117,985	14,942	668,553	801,480		801,480	(40,586)	760,894		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,242,898	218,711	1,051,513	2,513,122		2,513,122	(46,172)	2,466,950		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number

CARLINVILLE REHAB &amp; HCC

#0030411

Report Period Beginning:

7/1/2004

Ending:

6/30/2005

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			154,393	154,393		154,393		154,393			30
31	Amortization of Pre-Op. & Org.			14,921	14,921		14,921	(14,921)				31
32	Interest			462,489	462,489		462,489	(1,594)	460,895			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,020	2,020		2,020		2,020			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			633,823	633,823		633,823	(16,515)	617,308			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		83,814	31,940	115,754		115,754		115,754			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,655	53,655		53,655		53,655			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		83,814	85,595	169,409		169,409		169,409			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,242,898	302,525	1,770,931	3,316,354		3,316,354	(62,687)	3,253,667			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **CARLINVILLE REHAB & HCC**# **0030411**Report Period Beginning: **7/1/2004**Ending: **6/30/2005****VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer-</b>	<b>OHF USE</b>	
			<b>ence</b>	<b>ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,144)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,594)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,947)	21		18
19	Entertainment				19
20	Contributions	(250)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(21,652)	21		24
25	Fund Raising, Advertising and Promotional	(26,529)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,554)	36		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (60,670)</b>		<b>\$</b>	<b>30</b>

<b>OHF USE ONLY</b>						
48		49	50	51	52	

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization & Pre-Operating Expense	(14,921)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)	12,904	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (2,017)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (62,687)</b>		<b>37</b>

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.		X	\$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

STATE OF ILLINOIS  
CARLINVILLE REHAB & HCC

Page 5A

ID# 0030411  
Report Period Beginning: 7/1/2004  
Ending: 6/30/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Raw Foods Rebate	\$ (442)	2	1
2	Misc Income	(1,112)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,554)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number CARLINVILLE REHAB &amp; HCC

# 0030411

Report Period Beginning:

7/1/2004

Ending:

6/30/2005

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	(5,144)	0	0	0	0	0	0	0	0	0	0	(5,144)	1
2	Food Purchase	(442)	0	0	0	0	0	0	0	0	0	0	(442)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(5,586)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(5,586)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,066	0	0	0	0	0	0	0	0	0	2,066	19
20	Fees, Subscriptions & Promotions	(26,529)	0	0	0	0	0	0	0	0	0	0	(26,529)	20
21	Clerical & General Office Expenses	(26,961)	272	0	0	0	0	0	0	0	0	0	(26,689)	21
22	Employee Benefits & Payroll Taxes	0	6,230	0	0	0	0	0	0	0	0	0	6,230	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	673	0	0	0	0	0	0	0	0	0	673	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	3,663	0	0	0	0	0	0	0	0	0	3,663	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(53,490)</b>	<b>12,904</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(40,586)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(59,076)</b>	<b>12,904</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(46,172)</b>	<b>29</b>

## Summary B

6/30/2005

[illegible]

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name <a href="#">See Attached Listings</a>	City	Name	City	Type of Business
N/A						

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5 Heat and Other Utilities	\$	Midamerica Care Foudation	100.00%	\$		1
2	V	19 Professional Services		Midamerica Care Foudation	100.00%	2,066	2,066	2
3	V	20 Due, Fees, Subscriptions & Promotions		Midamerica Care Foudation	100.00%			3
4	V	21 Clerical & Other General Office		Midamerica Care Foudation	100.00%	272	272	4
5	V	22 Employee Benefits		Midamerica Care Foudation	100.00%	6,230	6,230	5
6	V	24 Travel & Seminar		Midamerica Care Foudation	100.00%	673	673	6
7	V	26 Insurance		Midamerica Care Foudation	100.00%	3,663	3,663	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$ 12,904	\$ * 12,904	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARLINVILLE REHAB & HCC # 0030411 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CARLINVILLE REHAB & HCC # 0030411 Report Period Beginning: 7/1/2004 Ending: 7/30/2005

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization MidAmerica Care Foundation  
 Street Address 7611 State Line Rd Ste 301  
 City / State / Zip Code Kansas City, MO 64114  
 Phone Number (816-444-0900)  
 Fax Number ( )

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5 Heat and Other Utilities	Patient Days	205,997	7	\$	\$	25,669	\$ 0	1
2	19 Professional Services	Patient Days	205,997	7	16,582		25,669	2,066	2
3	20 Due, Fees, Subscriptions & Promos	Patient Days	205,997	7			25,669	0	3
4	21 Clerical & Other General Office	Patient Days	205,997	7	2,179		25,669	272	4
5	22 Employee Benefits	Patient Days	205,997	7	50,000		25,669	6,230	5
6	24 Travel & Seminar	Patient Days	205,997	7	5,402		25,669	673	6
7	26 Insurance	Patient Days	205,997	7	29,400		25,669	3,663	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 103,563	\$		\$ 12,904	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest:** (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1	Carlinville Class 6(E) Bonds		X	Mortgage	Varies	1/1/85	\$ 3,700,000	\$ 3,860,485	11/1/2015	0.1200	\$ 463,258	1							
2	Bonds Repurchased		X					(5,901)			(1,884)	2							
3	Macoupin County Treasurer		X	Past Due R/E Taxes	Varies	4/1/91	74,958	8,469	4/1/2006	0.0900	1,115	3							
4												4							
5												5							
	Working Capital																		
6	Interest Income		X								(1,594)	6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 3,774,958	\$ 3,863,053					\$ 460,895	9					
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$					\$	14					
15	TOTALS (line 9+line14)						\$ 3,774,958	\$ 3,863,053					\$ 460,895	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

B: Real Estate Taxes																												
1. Real Estate Tax accrual used on 2004 report.	<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1																									
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2																									
3. Under or (over) accrual (line 2 minus line 1).		\$	3																									
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																									
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5																									
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6																									
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																									
Real Estate Tax History:																												
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2000</td><td>8</td></tr> <tr><td>2001</td><td>9</td></tr> <tr><td>2002</td><td>10</td></tr> <tr><td>2003</td><td>11</td></tr> <tr><td>2004</td><td>12</td></tr> </table>	2000	8	2001	9	2002	10	2003	11	2004	12	<table border="1"> <tr> <th colspan="2">FOR OHF USE ONLY</th> <th></th> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2004</td> <td>\$</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> </tr> </table>		FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2004	\$	14	PLUS APPEAL COST FROM LINE 5	\$	15	LESS REFUND FROM LINE 6	\$	16	AMOUNT TO USE FOR RATE CALCULATION	\$
2000	8																											
2001	9																											
2002	10																											
2003	11																											
2004	12																											
FOR OHF USE ONLY																												
13	FROM R. E. TAX STATEMENT FOR 2004	\$																										
14	PLUS APPEAL COST FROM LINE 5	\$																										
15	LESS REFUND FROM LINE 6	\$																										
16	AMOUNT TO USE FOR RATE CALCULATION	\$																										

1. Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME CARLINVILLE REHAB & HCC COUNTY MACOUPIN

FACILITY IDPH LICENSE NUMBER 0030411

CONTACT PERSON REGARDING THIS REPORT Ken Marx, BKD, LLP

TELEPHONE 314-231-5544 FAX #: 314-231-9731

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>N/A</u>	<u></u>	\$ <u></u>	\$ <u></u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		<b>TOTALS</b>	\$ <u></u>	\$ <u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

A. Square Feet:
 25,000
 B. General Construction Type:
 Exterior
 BRICK & BLOCK
 Frame
 Number of Stories
 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☐ NO
 If so, please complete the following:

1. Total Amount Incurred:
 406,451
 2. Number of Years Over Which it is Being Amortized:
 Various

3. Current Period Amortization:
 14,921
 4. Dates Incurred:
 Various

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		25,000		\$	1
2					2
3	TOTALS	25,000		\$	3

Facility Name &amp; ID Number CARLINVILLE REHAB &amp; HCC

# 0030411

Report Period Beginning:

7/1/2004

Ending:

6/30/2005

**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		85	75	\$ 2,603,743	\$ 86,791	30	\$ 86,791		\$ 1,706,898	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Improvements 1986		86		200,948	6,798	29	6,798		130,436	9
10	Improvements 1987		87		2,931		15			2,902	10
11	Improvements 1990		90		7,589		12			7,589	11
12	Improvements 1991		91		72,467		7			72,252	12
13	Improvements 1992		92		9,707		7			9,707	13
14	Improvements 1993		93		27,841		7			27,841	14
15	Improvements 1994		94		25,815	218	Various	218		24,080	15
16	Improvements 1995		95		38,667	3,072	Various	3,072		31,364	16
17	Improvements 1996		96		27,537	1,194	Various	1,194		17,700	17
18	Improvements 1997		97		41,359	2,440	Various	2,440		20,030	18
19	Improvements 1998		98		6,964	518	Various	518		3,578	19
20	Improvements 1999		99		16,785	1,304	Various	1,304		7,713	20
21	Improvements 2000		2000		7,939	564	Various	564		2,655	21
22	Improvements 2001		2001		18,671	2,105	Various	2,105		7,681	22
23	Vinyl Cove Base		2002		727	73	10	73		248	23
24	Fire Doors (5)		2002		9,990	500	20	500		1,707	24
25	Laminated Doors (50)		2002		67,913	6,791	10	6,791		21,506	25
26	Wallcoverings (2930 yards)		2003		21,184	4,237	5	4,237		15,182	26
27	Nurse Station		2003		7,154	477	15	477		1,431	27
28	Ambulance Portico		2003		24,533	1,227	20	1,227		2,964	28
29	Nurse Station Wallcovering		2003		5,600	1,120	5	1,120		3,827	29
30	Interior Painting for Patient Rooms & Bathrooms		2003		46,312	9,262	5	9,262		30,103	30
31	Nurse Call System		2003		2,850	285	10	285		570	31
32	Sprinkler system in new addition		2003		1,711	68	25	68		131	32
33	Roof		2004		47,743	2,387	20	2,387		3,616	33
34	Hot water heater		2005		4,895	122	10	122		122	34
35	Trim Trees on Property & Remove Brush		2002		1,095	110	10	110		329	35
36	Sign		2004		3,285	274	10	274		274	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,353,955	\$ 131,937		\$ 131,937	\$	\$ 2,154,436	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 396,651	\$ 21,476	\$ 21,476	\$		\$ 269,998	71
72	Current Year Purchases	8,715	980	980			990	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 405,366	\$ 22,456	\$ 22,456	\$		\$ 270,988	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,759,321	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 154,393	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 154,393	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,425,424	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: **N/A**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<b>N/A</b>			\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☒ YES ☐ NO

16. Rental Amount for movable equipment: \$ **2,020**

Description: **See attached detail for rental expense**

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<b>N/A</b>		\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. **/2006** \$

13. **/2007** \$

14. **/2008** \$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* **This amount plus any amortization of lease expense must agree with page 4, line 34.**

**A. TYPE OF TRAINING PROGRAM** (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER CNA _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER CNA _____
--	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	CNA Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a, 3	hrs	\$	1,042	\$ 52,479	\$	1,042	\$ 52,479	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		103	6,321		103	6,321	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		1,017	51,631		1,017	51,631	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	2,162	\$ 110,431	\$	2,162	\$ 110,431	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 144,852	\$	1
2	Cash-Patient Deposits	10,572		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	535,822		3
4	Supply Inventory (priced at )	13,081		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,798		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 710,125	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	9,750		12
13	Land			13
14	Buildings, at Historical Cost	3,336,167		14
15	Leasehold Improvements, at Historical Cost	17,786		15
16	Equipment, at Historical Cost	405,366		16
17	Accumulated Depreciation (book methods)	(2,425,413)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	406,451		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(273,619)		20
21	Restricted Funds	5,549		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,482,037	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,192,162	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 142,406	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,572		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	51,155		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,768		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	4,944,800		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Other Accrued Expenses</u>	14,056		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 5,176,757	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	3,854,585		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 3,854,585	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 9,031,342	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (6,839,180)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,192,162	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ (6,514,495)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ (6,514,495)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(324,685)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (324,685)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (6,839,180)</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,674,143	1
2	Discounts and Allowances for all Levels	(138,277)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,535,866	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	227,316	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 227,316	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	5,144	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	142,226	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,001	19
20	Radiology and X-Ray		20
21	Other Medical Services	54,851	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 232,222	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,594	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,594	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Transportation	(5,331)	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (5,331)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,991,667	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	531,856	31
32	Health Care	1,179,784	32
33	General Administration	801,480	33
<b>B. Capital Expense</b>			
34	Ownership	633,823	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	115,754	35
36	Provider Participation Fee	53,655	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,316,352	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(324,685)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (324,685)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	6,325	7,100	\$ 190,783	\$ 26.87	1
2					2
3	3,808	4,128	71,045	17.21	3
4	12,576	13,516	192,030	14.21	4
5	45,625	47,463	409,464	8.63	5
6	1,960	2,182	20,812	9.54	6
7					7
8					8
9					9
10	2,886	3,284	36,822	11.21	10
11	5,072	5,389	62,034	11.51	11
12	13,033	13,583	105,128	7.74	12
13					13
14					14
15					15
16					16
17	2,065	2,285	31,105	13.61	17
18					18
19					19
20	2,299	2,583	69,798	27.02	20
21					21
22					22
23	4,190	4,491	48,187	10.73	23
24					24
25					25
26					26
27					27
28					28
29					29
30					30
31	663	732	5,690	7.77	31
32					32
33					33
34	100,502	106,736	\$ 1,242,898 *	\$ 11.64	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	107	\$ 8,926	1, 3	35
36	78	11,518	9, 3	36
37	43	1,440	10, 3	37
38				38
39	79	3,888	10, 3	39
40				40
41				41
42				42
43				43
44	52	2,528	11, 3	44
45	64	2,528	12, 3	45
46				46
47				47
48				48
49	423	\$ 30,828		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50		\$		50
51				51
52				52
53		\$		53

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Suzanne Boston	Admin		\$ 32,139	Workers' Compensation Insurance	\$	79,322	IDPH License Fee	\$
Georgann Foster	Admin		23,956	Unemployment Compensation Insurance			Advertising: Employee Recruitment	3,364
Carl Johnson	Admin		6,923	FICA Taxes		96,835	Health Care Worker Background Check	
Janet Robertson	Admin		6,780	Employee Health Insurance		21,894	(Indicate # of checks performed _____)	
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*				
				Other Benefits		6,583	Dues & Subscriptions	11,354
							Advertising & Public Relations	26,529
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 69,798					
B. Administrative - Other				Home Office Allocation			Less: Public Relations Expense	
Description			Amount				(	)
			\$				Non-allowable advertising	(26,529)
							Yellow page advertising	(
								)
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)						\$ 210,864		\$ 14,718
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Legal Fees	Various		\$ 23,217			\$	Out-of-State Travel	\$
Purchased Service	Various		26,840					
Data Processing	Various		9,368					
Accounting	Various		10,066				In-State Travel	16,268
Professional Services	Various		540					
Management Fees	Various		179,438					
Trustee Expense	Various		4,000				Seminar Expense	
							Home Office Allocation	673
							Entertainment Expense	(
							(agree to Sch. V, line 24, col. 8)	)
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			TOTAL	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 253,469			\$		\$ 16,941

\* Attach copy of IMRF notifications

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

[illegible]

Facility Name & ID Number **CARLINVILLE REHAB & HCC**

STATE OF ILLINOIS

# **0030411**

Report Period Beginning: **7/1/2004**

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Ending: **6/30/2005**

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. 7722 - Illinois Health Care Assoc.
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 7.6
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,050 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 53,655  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? YES Indicate the amount. \$ 3,202
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: BKD, LLP KCKN The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. In Progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.